WARD v. WILBANKS, ET AL

PERRY CLARK FRANCIS

December 17, 2009

Prepared for you by

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PERRY CLARK FRANCIS
December 17, 2009

IN THE DISTRICT COURT OF THE UNITED STATES

FOR THE EASTERN DISTRICT OF MICHIGAN

SOUTHERN DIVISION

JULEA WARD,

Plaintiff,

vs. Case No. 2:09-cv-11237-GCS-PJK

Hon. George Caram Steeh

ROY WILBANKS, et al.,

Defendants.

_____

The Deposition of PERRY CLARK FRANCIS,

Taken at 101 North Main Street, Seventh Floor

Ann Arbor, Michigan,

Commencing at 2:17 p.m.,

Thursday, December 17, 2009,

Before Leisa M. Pastor, CSR-3500, RPR, CRR.

situations where, perhaps, concerns were raised, but they weren't sufficient enough to warrant an informal review process?

A. That would be correct.

Q. So, with those students, they would still be approved for practicum?

A. Yes.

Q. Or would someone just be outwardly denied?

A. Let's say professor A brings up a concern about student Z, Professor B, C, and D say we have not seen this behavior, or it's by been my experience this student has demonstrated these skills very well in this particular course. That may satisfy Professor A that what they were seeing did not rise to the level to deny a student admission into practicum.

Q. Is a student ever denied for practicum without going to an informal review conference?

A. A student, if they're denied for practicum, immediately go to an informal review.

Q. How many clients, on average, do you get each -- each semester at the counseling clinic?

A. In the fall, and winter, if we have 15, a full contingent of 15 clinicians, or clinicians in training, each clinician will start the first week with one, and then continue on and then build up. So,

I couldn't give you an accurate number, because they come and go, and sometimes a client might stay for the full 15 weeks and sometimes not. It's not a number that I regularly look at.

Q. Can you give me an estimate, based on your experience running the clinic?

A. I can give you a range.

Q. Sure, that'd be fine.

A. Anywhere from 75 to 125.

Q. And that's for each semester?

A. That would be fall and winter. In the spring/summer, when we only have five or six clinicians, you figure five clients per clinician, and then some rotating in and out, you could have a range of anywhere from 25 to 45.

Q. So you limit the number of clients that you see, based on the clinicians that you have available?

A. Correct.

Q. Has there ever been a situation where a client has needed to continue counseling past a given semester?

A. That is correct, yes.

Q. That's occurred?

A. Mm-hmm.

Q. What do you do? My -- what do you do with a client, in that circumstance? Do you -- is the -- does this

-- does the student who's been seeing that client continue to see that client, or do you transfer that client to somebody else, to accommodate them in some other way?

A. In a particular case, if counselor A sees a client, let's say, for five sessions, and the semester comes to a close, especially towards the end of a semester, we inform all clients you're coming to the close of a semester, you might just see this clinician five times. If the client agrees and understands that, then the client moves forward. They see the counselor five times. At the end of that, they do a termination session where, in most cases, the counselor-in-training and the client talk about what gains have been made, what other things could they work on, what goals have been met, what goals haven't been met, and then they say, "Would you like to continue on counseling next semester with a new clinician?"

The client then has the ability to say yes, no, or maybe. We have an active, pending, and, you know, closed case. The client is then put on the list for the next semester. When the next semester gets started, they are first in the rotation to receive a counselor-in-training, and begin the process over

again. We want to ensure that the client is given the opportunity, the autonomy to say yes, no, or maybe -- it's their decision -- as well as review with them what progress they've made and what goals they might want to additionally seek in the future.

Q. How often each semester would you say clients are carrying over and switching from one student to a different student in the --

A. I really don't know, I don't keep track of that.

Q. Does -- in your experience, does it happen a lot, a little?

A. I can't give you a number, because I don't know. I do know that it does happen.

Q. Okay. Do you have any supervisory responsibilities over the students who are in -- actually engaging in the counseling, or is that supervisory role satisfied solely by whoever the supervising professor is for that particular standpoint?

A. Supervision comes in two forms, administrative supervision and clinical supervision. Now nothing's ever quite that, you know, clean or dichotomous. My job, as the administrator of the clinic, is to provide administrative supervision. So I manage the process of, you know, clients coming in, making sure that the clinic's running smoothly, answering questions to

clients, to counselors-in-training about particular processes, keeping files where the files are kept, and such.

When I offer clinical supervision, it's usually because the clinical faculty member, the supervising faculty member is either not available or it's an emergency situation. So I may get called in in the cases I have in the past, when a client demonstrates, say, suicidal ideation or talks about child abuse. And it may be during the day before their faculty supervisor has arrived, or isn't in that day. In that particular case, I would provide clinical supervision, or I would intervene directly, ensuring the safety of the client, because the client's safety and needs are paramount for us.

Q. Is the -- is the primary responsibility for providing supervision for the students enrolled in practicum with the supervising faculty that are overseeing that student's practicum course?

A. Primary clinical supervision is provided by the faculty supervisor, who has the responsibility for that particular pod of students.

Q. When a client comes to the clinic, first visit--

A. Mm-hmm.

Q. -- prior -- yeah, first visit, and says they want to

engage the clinic's counseling services, walk me through the process, what happens with that particular person?

A. Generally someone would call, either because of referral from various sources, or because they have found us through various referral sources, call the clinic, the secretary, my GA, or I would take the call and gather particular information. Name, address, phone number, e-mail, and generally what's the presenting issue. I try my best to screen out those clients who are presenting with issues that are beyond the skill level of the clinicians that we have. In other words, we have beginning level clinicians; so, I'm not going to take someone who's actively suicidal, that would be inappropriate, and then I would make a referral to someone outside, you know, give them three or four names or other resources where they could find services. The paper, the initial client contact form would be given, then, to my GA, who handles the appointment book. She would then contact that particular client, and find an appropriate time for them to meet with our clinician, and depending upon the availability of the clinician.

Q. Who is the GA that you -- that oversees the assigning of the clients?

A. During Julea Ward's time, it was Shannon Thayer.
Q. Is that a rotating position that students fill from time to time, or is there -- is it a permanent position?
A. Well, "permanent" in any university setting is nebulous, at best, when it comes to students. It is a GA graduate assistant position. So, GAs are assigned. My GA, or the GA that works basically for me at the clinic, I generally try and keep for two to two and a half to three years. So, throughout the duration of their education.
Q. What's your role in the actual assignment of a prospective client to a student counselor? What do you do in that process?
A. I hand it to my GA, who has made it -- in this particular case, Shannon Thayer. And, you know, now Shannon's not there, Shannon's graduated, but in Shannon's case, she would often tell me to stay out of the appointment book, because I'd screw things up.
Q. So, did she have autonomy to assign clients to student counselors as she saw fit, as far as the scheduling availability went?
A. She had limited autonomy, in the sense that what I would do is hand her the initial contact form; she would match up times to clients, to counselors and

then contact the prospective client and offer whatever times that we had.

Q. Would you approve the client assignment, or would that be something that she would just handle on her own?

A. There's no approval or disapproval. It's, here's the client, here's the time, here's the clinician, do it. There are particular times where, if a particular client, per se, is a child, and we have certain clinicians who want to have experience with children, and if they're available, then we can match.

Q. So let's -- you do, at times, do matching, based on what a client needs and is presenting, and what a counselor's interested in getting experience based on?

A. No. It mostly has to do with population base, child, adolescent, adult.

Q. So -- but your testimony, I believe, was that if, say, there's a child client and there's a student and counselor who wants some experience counseling a child, that you would attempt to match those, the client with that counselor, so that they could gain that experience?

A. The difference in languaging (sic) is, that's a population issue. In other words, somebody wants experience with a child, not a particular demographic, in the sense of depression, anxiety, a particular

diagnosis.
Q. So you do population matching, but not diagnosis matching?
A. Yes.
Q. So if a student said, I have struggled and would like to increase my skill set when it comes to people presenting with the issue of depression, you'd make no attempt to get that particular student counselor individuals who are presenting with the issue of depression?
A. Generally, no.
Q. But you potentially would, or you just would not?
A. If the occasion arose and we were able to, but that's, again, happenstance.
Q. Can you think of any circumstances, specific circumstances, where you have matched a client with a counselor for a particular reason?
A. Other than, say, child, adolescent, and adult, I cannot recall an occasion at this time.
Q. Can you think of any situation where you avoided assigning a particular client to a particular counselor, for any particular reason?
A. Yes.
Q. Okay. Can you tell me about those situations?
MR. GREDEN: And just to clarify, please

don't reveal any student names or client names.

THE WITNESS: Thank you.

A. A client, or a counselor, who had just suffered the loss of a significant person in their life, and a client who had a -- was coming in to deal with grief issues. So, in that particular case, we thought it better not to do that.

BY MR. TEDESCO:

Q. Okay. Were there any other -- are there any other situations?

A. I cannot think of any others. Generally. In practicum, and this is not an intentional thing, you get the clients you need, not the clients you want.

Q. What do you mean by that?

A. You get the clients who present to you issues that help you stretch and learn and grow, not the clients that you can softball.

Q. So does that -- is there -- is there an intentional -- let me restate the question.

In the process of assigning clients to student counselors, do you or your staff actively seek to assign a client to a counselor, because you know that counselor needs to be stretched on a particular issue?

A. No, it all happens by happenstance.

Q. Okay. Have you ever done that in your -- recollection? Have you ever had a situation where you thought, this particular counselor could probably benefit from having this client assigned to them, because it will stretch some -- some boundary issues, or something that they're struggling with?

A. No.

MR. TADESCO: At this point, I'm going to pull these exhibits that we're going to classify the deposition into different categories, so...

* * *

BY MR. TEDESCO:

Q. Back to Exhibit 1, Leigh, if you could hand that over.

A. You know, I want to address something. It's an interesting question that you ask -- that, at times, a client may not like your style, and it just has to do with style, tone of voice, who you are, that they may want a more directive style, or a less directive style.

That has more to do with style, and that's what I mean when I say, you don't get along with all clients, and all clients don't get along with you. It doesn't go towards direction of a values issue, because that's not an issue that you bring up. You -- you are the blank slate for the client to bounce

counselor who is seeing that person to try and become aware of and deal with those issues in an appropriate and therapeutic way, not just for the client, but for the counselor.

Q. But if the counselor comes to the conclusion that, I think -- not out of animosity towards the client--

A. Mm-hmm.

Q. --but because they want to be as helpful as they can be to the client, that those values situation is not -- is going to potentially negatively impact the session, is it okay for them to refer the client to someone else, at that point, after going through supervision, education, and things like that?

A. I would, then, suggest that they continue to receive additional supervision and, in fact, might consult with or have a colleague monitor their work, to ensure that that doesn't happen. And, that if that does leak, that they can become aware of it and deal with it.

Q. If the counselor believes that that's just not going to be possible, what's their -- what's their option?

A. I'm not sure there is an option.

Q. You either continue as a professional counselor or you don't?

A. If there are issues that are so paramount to you that

you cannot suspend them, bracket them off so that you can be fully present with someone in their pain, then I would suggest that you may not be appropriate for the profession at this time.

Q. Let's -- let's go to Exhibit 1 now.

MR. TEDESCO: Leigh, are you going to be asking some questions, as well?

MR. GREDEN: I will, but not that many.

MR. TEDESCO: Okay.

BY MR. TEDESCO:

Q. If you could turn with me, Dr. Francis, in Exhibit 1, to page 59. The provision C5, Nondiscrimination, I'm just going to read that into the record. It says, "Counselors do not condone or engage in discrimination based on age, culture, disability, ethnicity, race, religion/spirituality, gender, gender identity, sexual orientation, marital status/partnership, language preference, socioeconomic status, or any basis prescribed by law. Counselors do not discriminate against clients, students, employees, supervisees, or research participants in a manner that has a negative impact on those persons."

I just want to ask you a series of questions, a series of questions about this provision. First of all, the provision states that counselors

cannot condone any of these forms of discrimination. What does condone mean, within the context of this provision?

A. To agree and/or promote.

Q. Can you give me an example of improper condoning of discrimination?

A. That I would believe that persons involved in an interracial marriage to be improper, immoral, and contrary to the human condition.

Q. So if you believe that, that's an improper condoning of discrimination under this policy?

A. Yes.

Q. Is there anywhere within Eastern Michigan-- I'm sorry, restate the question.

Is there anywhere within the Counseling Student Handbook that the term, condone, is defined within the context of this policy?

A. Not that I'm aware of.

Q. Are there any other EMU documents or policies that define what condone means?

A. Not that I'm aware of.

Q. How about the term, culture? What does culture mean within the context of this policy?

A. Culture are those values, practices, opinions of a group of people that help define them and their

actions and behaviors.
Q. Is there anywhere in the Eastern Michigan University Counseling Student Handbook where culture is defined?
A. Not that I'm aware of.
Q. Is it defined in any other EMU documents or policies?
A. It is discussed at length in Counseling 571, Cross-Cultural Counseling.
Q. Anywhere else you can think of?
A. It may be mentioned in other classes, as it arises.
Q. How about religion, what does religion mean within the context of this policy?
A. Religion is a set of beliefs, in most cases, an organized set of beliefs, adhered to and practiced by a group or groups of people.
Q. What's the difference between religion and spirituality?
A. Religion is a set of beliefs, practices, that are organized and adhered to by a particular group of people, whereas spirituality, in many cases, has to do with how one practices their belief system in a personal way, that may not have to do with any particular organized religion, and deals with their actions in how it is reflected with either their relationship with a higher power or some identified system of behaving.

Q. Is there anywhere within the counseling student handbook where those definitions you gave of religion and spirituality are specified?
A. Not that I'm aware of.
Q. Is there anywhere else, within EMU documents or policies, where these terms are defined?
A. This would have been covered, in one way or another, in Counseling 571, the cultural counseling, inter-cultural counseling course. There are no other places that I'm aware of, within the documents and policies.
Q. How about gender identity? What does it mean, within the context of this policy?
A. Gender identity is how a person perceives and expresses their gender.
Q. What falls under -- what genders are protected by this -- by this provision, and by this term, gender identity?
A. Would be people who express themselves, male, female, androgenous, nongender, transgendered.
Q. Does the counseling student handbook define gender identity anywhere?
A. Not that I'm aware of.
Q. How about any other EMU documents or policies? Do they define gender identity anywhere?

A. Not that I'm aware of.
Q. Sexual orientation is also included in the policy. Can you define what sexual orientation means for me?
A. Sexual orientation is an expression of one's gender, in the sense of how I practice or perceive my sexuality -- either as heterosexual, homosexual, or neither.
Q. What is neither?
A. Someone who is -- does not view themselves as attracted to either gender, even have, you know, bisexual, heterosexual, homosexual, and "I'm not attracted to anybody."
Q. Okay. I had not heard of that.
A. I actually had a client like that.
Q. Okay. Does the counseling student handbook provide a definition anywhere of sexual orientation?
A. Not that I'm aware of.
Q. Do any other EMU documents or policies define what sexual orientation means?
A. These are all issues that are brought up and covered in various classes, more specifically in the Cross Cultural Counseling Course, Counseling 571. I do not know of it in any other policy or procedure.
Q. Can you tell me what marital status means, within the context of this policy?

A. Marital status, married, unmarried, divorced, single, separated.
Q. Anything else?
A. I'm sure there are, but I couldn't name every one of them. I'm sure that might deal with cultural issues.
Q. Okay. In what way would that deal with cultural issues?
A. How a particular culture views marital status.
Q. Is polygamy a marital status?
A. In Arizona City.
Q. Is it one -- polygamy protected by this prohibition on marital status discrimination?
A. Yes.
Q. How about -- well, can you define for me what a polyamorous relationship is?
A. Polyamorous would then be, as the word states, many loves, having or seeking the love from several people.
Q. Would it be protected by this provision?
A. Yes.
Q. What's the difference between marital status and marital partnership?
A. Whereas a marital partnership, it may be a relationship that, say, mimics marriage in the sense that you have two people who've agreed to come together and operate as a couple; or, to take it to

the extreme that you were taking it, as a team, and may not have the legal aspects of marriage, as defined by the State.

Q. Are the terms marital status and marital partnership defined anywhere in the counseling student handbook?

A. Not that I'm aware of.

Q. Are they defined anywhere else in Eastern Michigan University documents or policies?

A. Not that I'm aware of.

Q. How about language preference, what does that mean within the context of the policy?

A. We are becoming a much more diverse culture. And as our culture becomes more diverse, there are more and more people whose primary language is something other than English, or American, depending on which side of the pond you're on. And so, a client may come in with a language preference for something other than English. We do not discriminate and force somebody to talk in a language that they are uncomfortable with, with us, and would interfere with our ability to provide services.

Q. Can you give me an example of a language preference discrimination?

A. In a school counseling situation, where a student who would come in who may be new to the United States and

speaks only, say, a language other than English -- let's pick one that's easy, Spanish. And I, as the counselor, do not speak Spanish. If I were to try and force the client only to speak English to me, that would be discriminatory. I'm under obligation to see if I can either find a person to translate for me, in making sure that that person understands the bounds of the counseling relationship, so that they -- I can communicate with that person, that's my responsibility. It would be discriminatory to force them to speak in a language that they may not understand.

Q. What if an interpreter was unavailable, you couldn't find somebody to do it, could you reassign that client, refer that client to someone who can speak Spanish and provide the service that the client needs?

A. If I'm unable to communicate with the client at all, and there's nobody available except another counselor, that would be a case where I might refer them. It would be discriminatory to only provide them English if another counselor is available, in this narrow circumstance, that nobody else is available to provide translation services.

Q. Is there anywhere within the Counseling Student Handbook where a definition of Language Preference

But not to abandon the client.

If you-- for example, I'll give you a very good example, it's called the "small town problem." You're the only counselor available within a hundred-mile radius, the client has no car, there's nobody else to provide service, then you need to do the best you can to provide the appropriate services to help them. It may be to wait-list them, if their issues are not life-threatening, that they cannot be delayed until you have an opening where you can provide services, then you wait-list them, and then provide the service.

Q. Just so I can understand your answer, would it be okay -- if alternative sources were available, alternative counselors were available -- for the counselor who couldn't accommodate that client who was unable to pay for the services, to that other counselor who was able to accommodate that client?

A. That is a practice that happens; and, in fact, it's how oftentimes we get clients at our clinic.

Q. If you could turn to pain 47 of Exhibit 1, Provision A4B, titled "Personal Values"?

A. Mm-hmm.

Q. And I'll just read that into the record. It says: "Counselors are aware of their own values, attitudes,

beliefs, and behaviors, and avoid imposing values that are inconsistent with counseling goals. Counselors respect the diversity of clients, trainees, and research participants."

Can you tell me what "imposing" means, within the context of this policy?

A. It would be -- it could be seen in different ways, by imposing what you believe to be the appropriate goals for the client; based on your value system of what you think the client should do. It could be based on imposing your particular views about how a client should behave, act, be perceived, within your value system.

Q. Is imposing values something that occurs within the context of the counseling session?

A. I'm not following your question -- at the --

Q. Can you run afoul of this provision, only when you're in the counseling session with the client, one-on-one? Is that when the imposing values can occur and be improper?

A. The counseling relationship begins from the moment the client makes a phone call to you, so imposing values or not imposing values begins from the moment the client calls. It begins, if you are assigned a client and you're reading their case notes, or reading their

referral photos. We read those, not based on our values, but based on what is in the best interests of the client. So, does it take place only in the context of when the person's in front of me? No, it can take place before I even see the client, by making judgments about them based upon what I might hear -- if a client calls and has a thick accent, and my values are, "all immigrants should be sent back to where they came from."

Q. Okay. How about -- I'm sorry, let me restate the question.

Okay, the policy says that you are not to impose your values when they are inconsistent with counseling goals.

A. The ethics say that.

Q. The ethics code says that.

A. Mm-hmm.

Q. Is it permissible then, under this policy, to impose your values when they are consistent with counseling goals that the client sets?

A. That would also be imposing values. Whether they agree with the client or not, my values are not -- are not what the session is about. It's working within the values of my client. So, I try and suspend or bracket off what I have, to be fully aware and present

with what the client brings in.
Q. The ethics code states, that you can't impose the values when they're inconsistent with counseling goals. Why doesn't it just say you can't impose values, if it's true that you can never impose values?
A. You'd have to ask the people who wrote this.
Q. Your understanding of this policy is that there's no time when you could impose your values, even if they're consistent with counseling goals set by the client?
A. There are the normal exceptions of saving a client's life; saving someone else's life who the client may seek to harm; but, beyond that, whether I agree with, or don't agree with the client, becomes secondary to what the client is bringing in to me, and what they're struggling with. I may agree with a client, and if I -- for some reason -- reveal my values, that may then imply to the client that other things that they're doing, I'm in agreement with, when I might not. And that would then interfere with the counseling relationship and cause the client to make assumptions that were incorrect.
Q. Is there ever a situation where, rather than imposing your values, you share your values with the client, where you think that it may be helpful to them,

beliefs or practices that would not -- that cause harm to people, that shouldn't be accorded the respect under this policy?

A. Not that I can think of, off the top of my head.

Q. Other than the couple that you've just referenced?

We're going to turn to Exhibit 2 now. And Dr. Francis, this is the ACA ethics opinion regarding conversion or reparative therapy? Are you familiar with this opinion?

A. Yes.

Q. And how did you become familiar with it?

A. It is one that I read about, and in fact, read this morning, again.

Q. Okay. And have you ever provided this ethics opinion to students in your classes?

A. No.

Q. Have you ever discussed it with students?

A. Yes.

Q. And what was the -- what class do you do that in?

A. It would have been discussed in any number of classes, specifically, ethical and legal issues and professional issues and counseling -- college counseling as well as discussing -- discussing nondiscriminatory practices within the counseling profession, in a course that we no longer teach that

has been subsumed into-- it's a professional orientation course. It has been subsumed into Counseling 505.

Q. And why did you -- why did you determine that you should hand this out to students and discuss it in class?

A. I didn't say I handed this out.

Q. Oh, that was my question, did you provide to students-- oh, I'm sorry, you said you discussed it.

A. Mm-hmm.

Q. Why did you determine that you should discuss it with students?

A. In the broader sense, it begins to deal with how we, as counselors, our professional orientation is to provide a nonjudgmental stance, and also to talk about that reparative and conversion therapy has no basis, currently, in science, and that the ACA, APA, and any other number of professional mental health associations have stated that reparative or conversion therapy is inappropriate for a science -- let me put it in a different way. It has not been proven to be effective through scientific, rigorous scientific study.

Q. Can you define for me what reparative therapy is?

A. Reparative and/or conversion therapy is therapy that

would move a client from the current sexuality that they believe that they have, to one that they may perceive that they need to have, according to society or a particular religious belief.

Q. On page 4 of this exhibit, point No. 5, it states that there are -- and I'm quoting the opinion now. It says, "There are treatments endorsed by the Association for Gay, Lesbian and Bisexual Issues in Counseling, a division of the American Counseling Association, and the American Psychological Association, that have been successful in helping clients with their sexual orientation. These treatments are gay-affirmative, and help a client reconcile his/her same sex attractions with religious beliefs."

Can you tell me what "gay-affirmative treatments" are?

A. These would be treatments that do not provide judgment, that if someone is homosexual, that they're bad or deviant, mentally ill, or have a pathology.

Q. And where it states that, "These gay-affirmative treatments help a client reconcile his/her same-sex attractions with religious beliefs," how do these gay affirmative treatment protocols assist clients in doing that?

A. It would be to help the client come to terms with what their particular religious belief might be, and what their particular sexual orientation might be, and help them struggle, wrestle, come to terms with how to bring those two together, or if they cannot bring those two together, how to live without that -- that bringing those two together, in a way that may be more helpful or healthful for them.

Q. Under gay-affirmative approach to therapy, if you had a client who stated that they were homosexual, but also stated to you that they came from a religious background in training, that taught that it was immoral to be homosexual or engage in homosexual relationships or behavior, would it be consistent with gay affirmative therapy to help that client embrace their religious beliefs and reject change their homosexual orientation?

A. I believe it would be appropriate to help the client deal with those goals that they bring forth into counseling. What you're stating is the counselor's agenda. I'm asking, is it the client's agenda?

Q. My question then, to clarify, is what if the client's goal, ultimately, is to embrace their religious values that teach that homosexual orientations, behaviors are immoral, and to ultimately change their -- their

referrals to gay-affirmative counselors, should they need to make a referral beyond that.

Q. I'm -- the counselor would have to provide the parents with the names of gay-affirmative counselors, as well?

A. Well, let's see what it says in here.

Q. Please.

A. Page 5, second paragraph: "There's also agreement among the committee members that any counselor stating that they can offer conversion therapy must also offer referrals to gay, lesbian, and bisexual affirmative counselors, and should discuss thoroughly the rights of the clients to seek professional counsel -- the professional's counsel."

Q. Well, that sentence seems to assume that there are some professional counselors that provide conversion therapy, correct?

A. Yes.

Q. And so, if you were the counselor that we just discussed, in that situation that I presented to you, and the counselor -- well, you said the counselor would have to discuss the scientific evidence regarding reparative therapy, and then provide an appropriate resource for those people to maybe go and get the help they want --

A. Well --

Q. And also to provide them with gay-affirmative counselors' names?
A. The person that is providing the conversion therapy needs to be able to also provide referrals, as it states here, to people who are gay, lesbian, bisexually-affirmative counselors. In other words, part of the things that I would then educate the parents on is, one, I can't provide the service; two, these are the things that you need to be aware of when working with someone who does provide these services, you know, they must be able to state to you that this is unproven, that, you know, what are the limitations, what are the benefits, what are the -- what has research shown this to do and not do? That, should this not be the way you want to go, here are the names of people who can provide affirmative counseling for your son or daughter.
Q. Okay.
A. So that I'm giving them the education that they need, and in a sense, a consumer protection advocate, saying to them, "here are the things that you need to be looking for in this particular case." Let's say you want to go get LASIKs (sic).
Q. Get what?
A. LASIKs.

Q. Eye surgery?
A. Eye surgery. Wouldn't you want the person who provides that for you, or recommends that to you, that these are the things you need to be looking for in a good LASIK surgeon.
Q. Are you asking me questions in my deposition?
A. Yes, I'm asking you questions in your deposition.
Q. I refuse to answer. I advise myself not to answer.
MR. GREDEN: Very good.
THE WITNESS: Isn't it true that the attorney who takes himself as a client has a fool for -- never mind.
MR. TEDESCO: Attorney jokes? Your attorney's sitting right next to you.
BY MR. TEDESCO:
Q. Just a couple more questions I want to ask you about. And this is in relation to the formal -- your participation in the formal review committee hearing, regarding Julea Ward's case.
A. Thank you.
Q. Prior to that hearing, other than your involvement with what happened in the counseling clinic --
A. Mm-hmm.
Q. -- with Julea, and Dr. Callaway --
A. Mm-hmm.

you know, and I'd say, "I really can't talk about it," I don't -- I do not recall. If you have something to show me, please.

Q. I don't. Just asking.

A. Yeah.

Q. Do you -- are you aware that Julea appealed the decision to Dean Polite?

A. Yes, we got a copy of his letter.

Q. Okay, in between the time that Dr. Ametrano sent the letter, informing Julea of her dismissal, and the ultimate resolution of the appeal by Dean Polite, did you have communications with anybody about the situation, e-mail, telephone, direct conversations?

A. Other than appropriate staff, Shannon, you know, who may be, you know, what's happening, oh, you know, not really able to discuss it, not that I recall.

Q. Would you tell them any details about the situation?

A. No. Not allowed to.

Q. Okay. Give me a minute just to make sure I've covered everything I want to cover.

MR. GREDEN: Let's go off the record for a minute.

(Off the record at 5:08 p.m.)

(Recess taken at 5:09 p.m.)

(On the record at 5:31 p.m.)

BY MR. TEDESCO:

Q. The final questions that we were talking about, right before we took a break, I want to -- I'm -- I want to make sure I understand your answer. If a counselor is in a situation where their clients are -- the clients are parents of a minor child, who recently told them that she's a lesbian and has come out to them, and the clients say, "We're here because we're deeply religious people, we think that this is immoral, that the behavior's immoral, that the -- thinking that you're a lesbian is immoral and wrong, we want you to help us help our daughter not be a lesbian, and not engage in --

A. Mm-hmm.

Q. -- homosexual behaviors and relationships, the counselor, in that setting, does what? Do they provide an appropriate referral to a counselor who does reparative therapy, or do they not provide a referral at all?

A. The counselor sits down. First, you want to, at the very least, empathize with their position, where they're at -- that this is a shocking situation, possibly, for them, or whatever they're feeling at that time. And then, to discuss with them, you know, again, you know -- not reaffirm, is not the word I'm

looking for, but to reconfirm what their goal is, to educate them concerning, you know, what is sexual development, how does it occur, and to talk about what we know from a science point of view, you know, what's going on here, and then to go on to talk about, you know, reparative therapy -- that it is not considered a standard of care that is supported by the mental health profession. And that, one, I do not provide that kind of care, it's just not within my skill set, nor is it something I've learned. Secondly, that I would then talk to them about, if you -- you know, if you choose to continue-- you know, I can't see you, because I don't provide that kind of care, that's not the standard of care within the profession.

Q. Okay.

A. Secondly, to talk about, these are the things that you should expect from somebody who does provide that therapy, and talk about what they should be looking for.

And then, to point them in the appropriate direction to find a referral. I don't have a referral. I don't know of anyone who provides that service, and I don't know of any counselors right now, in my professional contacts, that know of anybody that provides that service. But I would point them in the

direction of where they might find that, which could be through an American Association of Christian Counselors, AACC. I don't know if the Counseling and Psycholog -- or, Christian Association of Psychological Studies provides that type of referral service. I don't think so -- they've always struck me as not supporting reparative therapy. So, you know, point them in the direction of where they can find resources.

Q. Okay. Just a couple more questions. You mentioned two professors that you had talked to, in between the informal review conference and the formal review hearing, regarding Julea Ward's case.

A. I talked to two professors between when I was notified there would be a formal review, and before the formal review concert.

Q. Okay, and that notification occurred after the informal review conference occurred?

A. Correct.

Q. Okay. Did you -- what did you speak to them about, specifically?

A. The issue, as presented to me. Here -- here are the facts as I know them. What are your thoughts about this?

Q. Okay. And where did you get the facts from, that you

were explaining to them?
A. The facts, as I knew them, in the sense that, here we have a student who said, you know, from what I was exposed to down at the clinic, you know, here I have a student who was-- refused to see this particular client. The fact that, right after the informal review, I happened to be upstairs. My office is on the first floor, the department office and where my other office is is on the third floor, and I was upstairs when Dr. Callaway came out of the clinic, or came out of the conference room and said that Julea Ward's being suspended from practicum, and at that point, I had a good idea of what was going on, based on what had happened previously.
Q. Okay. Sorry?
A. Getting your addiction.
Q. Yeah, tell me about it.
When you spoke to Dr. Callaway, as you said, upstairs, what -- what was -- what else was discussed, if anything?
A. That was it. Because she was going to come downstairs and get Julea's tapes and any files that she might have, and anything she might have down in the clinic. And I said, don't worry about that, I'll take her downstairs, and I'll do that.

A. No. God no, that would be -- that would be thought control.

Q. You testified earlier today, under examination by Mr. Tedesco, that a single incident of bad rapport with a client does not necessarily -- demonstrate that a counselor has a skill deficiency; is that a fair representation of your testimony?

A. Yes.

Q. How do you distinguish between that situation, where a counselor-in-training may have a single incident of bad rapport, versus what you saw regarding Mrs. Ward's behavior?

A. A single incident of bad rapport can be remediated with simple supervision, dealing with skills, or administratively a simple, you know, you need to call the client and make sure you have everything ready when the client comes in. That's easily remedied by modifying behaviors. Julea Ward was not willing to modify her behavior, and her behavior was one that was pervasive over an entire class of people or people's, dealing with particular issues that could be considered -- that particular classes of people, whom she was discriminating against.

Q. You testified earlier today about Exhibit 1, page 59, section C5.

A. Mm-hmm.
Q. Do you recall that testimony?
A. Yes.
Q. I believe you were asked by Mr. Tedesco, how do you define the word "condone." And I believe you testified, agreed or promote; is that an accurate representation of your testimony?
A. Yes.
Q. You had started to provide an example of how you thought someone could condone discrimination, and I don't know if you were able to answer your question, so I wanted to give you that opportunity. The example you used was interracial marriage, and I just want you to try and finish your -- your answer. Do you recall that testimony, or do you --
A. Yes.
Q. Okay, how -- could you provide us the example you were thinking of, about how someone could condone discrimination, based on interracial marriage, in a way that would violate section C5 of the Code of Ethics?
A. Condone is to -- as I believe I've said, was to promote and/or support behaviors or ways of providing counseling that are discriminatory against a class of people, or a different type of people. That does not

mean that a counselor cannot believe what they want to believe. Counselors believe all sorts of things. We're a very varied profession within all the mental health professions. But to promote and/or actively practice behaviors that discriminate against a class of people is inappropriate, and violates these particular ethics codes. You're not providing appropriate clinical care to that class of people.

Q. You also testified earlier, under examination by Mr. Tedesco, that self-disclosure by a counselor, regarding the counselor's views or experiences, should be limited. And an example you provided was when a counselor has faced a similar situation. Is that an accurate summary of your testimony?

A. Yes.

Q. Are there times when such self-disclosure by a counselor could be harmful to a client?

A. Very much so.

Q. Could you give an example?

A. Let's use that same example and say, for example, a client was coming in to deal with their -- the ramifications of a divorce in their life. And let's say the counselor, for whatever reason, had also gone through a similar experience. The counselor, using self-disclosure, might then begin to talk about their

CERTIFICATE OF NOTARY

STATE OF MICHIGAN)
) SS
COUNTY OF MONROE)

I, LEISA PASTOR, certify that this deposition was taken before me on the date hereinbefore set forth; that the foregoing questions and answers were recorded by me, stenographically, and reduced to computer transcription; that this is a true, full and correct transcript of my stenographic notes so taken; and that I am not related to, nor of counsel to either party, nor interested in the event of this cause.

LEISA PASTOR, CSR-3500, CRR,
Notary Public,
Monroe County, Michigan
My Commission expires: 9/7/13